STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

REQUEST FOR PRIOR AUTHORIZATION AND/OR OUT OF STATE SERVICES

PLEASE FILL OUT FORM & ACCOMPANY WITH CURRENT CLINICAL REPORT FROM SPECIALIST

Child's Name: _____ ID#: _____

Child's DOB: _____ Child's County: _____

TYPE OF REQUEST (CHECK ALL THAT APPLY)

☐ Medication ☐ Transplant ☐ Surgical CPT Code(s): _____ ☐ Dental ☐ Other_____

☐ Out-of –state** (New) ☐ Extension/renewal** Date needed (if known): _____

Referring Specialist: _____

Hospital/Physician Name(being referred to): _____

Medicaid Provider ID# : _____ Physician Specialty:_____

Hospital/Physician Address: _____

Billing Address (if different): _____

Diagnosis Code(s) for this Request: _____

Fax Authorization: ☐ Yes ☐ No Fax # : _____ ATTN:_____

(PLEASE NOTE: IF AUTHORIZATION IS FAXED IT WILL NOT BE MAILED.)

PLEASE FAX ALL OUT OF STATE REQUEST TO CSHCS FAX # 517-335-8454

**OUT-OF-STATE SERVICE REQUEST must include the following:

☐ A letter from an in-state medical specialist stating:

a) the CSHCS diagnosis,
b) the reason for request diagnosis or treatment,
c) why in-state services are not appropriate,
d) why this specific physician/specialist,
e) plan for follow-up/transition to an in-state specialist (coordination with instate specialist)

Is Case Management being done by Local Health Department Yes ☐ No ☐
Is Care Coordination being done by Local Health Department Yes ☐ No ☐

CSHCS: INTERNAL USE ONLY

APPROVED ☐ **PEND** ☐ **DENY** ☐

BY: _____ **DATE:** _____

MEDICAL CONSULTANT/NURSE CONSULTANT

PROVIDERS ADDED? ☐**YES** ☐**NO** **BY:** _____ **DATE:** _____

APPROVED SERVICES: ☐**IN –PATIENT** ☐**OUT-PATIENT** ☐**RADIOLOGY** ☐**LAB** ☐ **ANESTHESIA** ☐**PHARMACY**

☐**OTHER**_____ **APPROVED DIAGNOSIS FOR THIS REQUEST** _____

COMMENTS: _____